Prior Authorization

Service	PA Contact	Special Instructions

• **All out-of-state hospital care**
• **All transplant services**
• **All in-state and out-of-state rehab services**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X150 Helena
	(800) 262-1545 X150 In and out of state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In and out of state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.
		• Emergency out-of-state services must be reported within two business days of admission. For example, a client admitted on Sunday must report admission by Wednesday.

• **Contact lenses (dispensing and fitting of)**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 Helena and out of state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Visual acuity (must document correction with glasses and with contact lenses)

• **Dental and Orthodontic Services**	Claims Processing Unit P. O. Box 8000 Helena, MT 59604 **Phone:** **(800) 624-3958** In state **(406) 442-1837** Out of state and Helena	• PA is required for all orthodontic services. • In certain circumstances, some limits may be exceeded if prior authorization is granted. • Send paper claims to this address. • For claims questions, call the number listed.
• **DME**	PA Program Officer Surveillance and Utilization Review Section Quality Assurance Division P.O. Box 202951 Helena, MT 59620-2951 **Phone:** **(406) 444-0190**	• Complete the prior authorization form in the DME provider manual and send the address shown.
• **EPSDT - Private Duty Nursing**	Mountain Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** **(800) 262-1545** In state **(406) 443-4020** Out of state and Helena **Fax:** **(800) 497-8235** In state **(406) 443-4585** Out of state and Helena	• Prior authorization is required for private duty nursing services.

Prior Authorization (continued)

Service	PA Contact	Special Instructions
• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** **(406) 444-0190** Helena and out of state **(406) 444-1441** Helena and out of state **Fax:** **(406) 444-0778**	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.
• **Hearing Aids**	Hearing Aid Program Officer DPHHS Health Policy and Services Division Medicaid Services Bureau P.O. Box 202951 Helena, MT 59620-2951 **Phone:** **(406) 442-1837** Helena and out of state **(800) 624-3958** In state	• Prior authorization is required for hearing aids. • Please complete the form from the Hearing Aid Services manual and include a copy of the referral from the physician or mid-level practitioner, and audiogram, and a report from the licensed audiologist.
• **Home and Community Based Services**	Contact you local area case management team (see *Case Management Teams* in the contacts listing).	• Prior authorization is required for services.
• **Home Health Services**	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** **(406) 443-0320** Helena and out of state **(800) 219-7035** In state	• Prior authorization required for home health services. • Authorization required for skilled nursing services in excess of 75 visits per state fiscal year (July - June).

• **Mastectomy**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-295
	
	Phone:
	(406) 444-0190 Helena and out of state
	(406) 444-1441 Helena and out of state
	Fax:
	(406) 444-0778
		• Client must be diagnosed with cancer.
		• Factors that may also be considered include:
		  • Presence of lobular carcinoma in situ is a risk factor for development of cancer in either breast.
		  • Having more than one first degree relative who has had breast cancer, particularly when one had bilateral cancer.
		  • Age at the time of diagnosis. Recurrence is more likely with younger clients.
		  • Oncological consultation that supports the bilateral mastectomy.

• **Mental Health Services**	First Health Services 4300 Cox Road Glen Allen, VA 23060 **Phone:** **(800) 770-3084** **Fax:** **(800) 639-8982** **(800) 247-3844**	• Prior authorization (PA) required for continued stay review for selected mental health services. • PA required for inpatient and residential services. • PA required for more than 12 visits between January 1, 2002 and June 30 2003. • PA required for more than 24 visits between July 01, 2002 and June 30, 2003.

Prior Authorization (continued)

Service	PA Contact	Special Instructions
• **Personal Care Services**	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** **(406) 443-4020** Helena and out of state **(800) 268-1145** In state	• Prior authorization required for personal care services.
• **Prescription Drugs** (For a list of drugs that require PA, refer to the *PA Criteria for Prescription Drugs later in this chapter.*)	Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** **(406) 443-6002** Helena **(800) 395-7961** In and out of state **Fax:** **(406) 443-7014** Helena **(800) 294-1350** In and out of state	• Refer to the *PA Criteria for Prescription Drugs* table in this chapter for a list of drugs that require PA. • Providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is in *Appendix A: Forms*. • The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the *PA Criteria for Specific Services* table.

• **Therapy Services**	Therapy Services Program Officer
	DPHHS
	Health Policy and Services Division
	P.O. Box 202951
	1400 Broadway
	Helena, MT 59620-2951
	
	Phone:
	(406) 444-4540 In and out of state
		• Therapy services are limited to the following amounts per client during the state fiscal year (July - June):
		  • speech - 70 units of service
		  • occupational - 70 hours of service
		  • physical - 70 hours of service
		• Prior authorization is required for an additional 30 hours of service during the state fiscal year.

• **Transportation (commercial and scheduled ambulance transport)**	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• All scheduled and non-scheduled transports require authorization.
		• For emergency ambulance transports, providers have 30 days following service to obtain authorization.
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID Number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

Prior Authorization (continued)

Service	PA Contact	Special Instructions

• **Reduction Mammoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-0190 Helena and out of state
	(406) 444-1441 Helena and out of state
	Fax:
	(406) 444-0778
		• Female client 18 years or greater with a body weight less than 1.5 times the ideal weight.
		• History of the client's symptoms related to larger, pendulous breasts. Back pain symptoms must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include all of the following conditions:
		  • Upper back, neck, shoulder pain and parasthesia radiating into the arms that has been unresponsive to at least six months of documented, notarized, and supervised physical therapy and strengthening exercises. If paresthesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must include the following:
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pathology report including weight of surgical specimen.
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.

Prior Authorization (continued)

Service	PA Contact	Special Instructions

• **Gastric Bypass**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-0190 Helena and out of state
	(406) 444-1441 Helena and out of state
	Fax:
	(406) 444-0778
		• Documentation in the referring physician's records of client's complaints that have been ongoing. All life threatening conditions must be stated in writing by the appropriate physician (e.g., uncontrolled hypertension, uncontrolled diabetes, CHF, and sleep apnea). Other complications (e.g., orthopedic, skin, wound, etc.) are not justification for the gastric bypass surgery.
		• The referring physician must submit medical records documenting the client's efforts to lose weight by conventional methods over the past five years. This documentation must indicate non-surgical methods which include a dietary regimen, appropriate exercise, and behavioral modification with support tried through at least two physician supervised programs. The duration, compliance, and results must be included in this documentation. Describe the program in which the client is actively participating. It is not adequate to take a written summary from the client or surgeon. Dietary regimen and exercise program documentation must include:
		  • Notarized dietary day book with documentation of daily caloric intake for one year.
		  • Exercise diary for one year with supervised exercise program (must be signed and notarized by exercise supervisor).
		• Physical exam verifying the degrees of obesity and related physical effects. Should include height, weight, and BMI. BMI must be 50 or greater. Pulmonary function testing is mandatory.
		• Describe the proposed surgical procedure and the appropriate code. Indicate if there will be a concurrent cholecystectomy screening criteria for Medicaid gastric bypass candidates.
		• Labs required: liver function, lipid levels, renal panel, CBS, thyroid panel/or TSH, two fasting blood sugars or a two hour glucose tolerance test, pulmonary function, sleep study.
		• Psychiatric evaluation (from a psychiatrist or a psychologist independent of the physician's group recommending the procedure) at least three months prior to the date of the surgery. This evaluation should attest to the ability of the client to understand the risks and requirements of the procedure, the likelihood of compliance by the client with the post surgical program as well as the current mental status. The presence or absence of any depression should be noted. If there is depression noted, it must be treated prior to the surgery.